



Independent Payment Advisory Board

One of the most controversial provisions of the Patient Protection and Affordable Care Act was the establishment of an Independent Payment Advisory Board (IPAB). While some applaud the new advisory board as a mechanism for controlling health care costs outside the influence of political processes and pressures, others have criticized the scope of its authority and the lack of flexibility in its mandate. Because of these serious concerns, the American Medical Association opposes the IPAB and supports its repeal.

What is the IPAB?

The Patient Protection and Affordable Care Act established a 15-member Independent Payment Advisory Board (IPAB) to extend Medicare solvency and reduce spending growth through use of a spending target system and fast track legislative approval process.

By April 30 of each year, beginning in 2013, the Centers for Medicare & Medicaid Services (CMS) Actuary's Office will project whether Medicare's per-capita spending growth rate in the following two years will exceed a targeted rate. Initially, the targeted rate of spending growth will be based on the projected 5-year average percentage increase in the Consumer Price Index for all urban consumers (CPI-U) and the Consumer Price Index for all urban consumers for medical care (CPI-M). Beginning in 2019, the target will be set at the nominal gross domestic product (GDP) per capita + 1.0 percent. If future Medicare spending is expected to exceed the targets, the IPAB will propose recommendations to Congress and the President to reduce the growth rate. The IPAB's first set of recommendations would be proposed on January 15, 2014.

Spending rate reductions will be established at: 0.5 percent in 2015; 1.0 percent in 2016; 1.25 percent in 2017; 1.5 percent in 2018 and beyond. If Congress fails to pass legislation by August 15 each year to achieve the required savings through other policy changes, the IPAB's recommendations will automatically take effect. The IPAB is prohibited from submitting proposals that would ration care, increase revenues, change benefits, modify eligibility, increase Medicare beneficiary cost sharing (including Parts A and B premiums), or change the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospice will not be subject to cost reductions proposed by the IPAB from 2015 through 2019. Clinical labs would be exempt for one year.

Beginning July 1, 2014, the IPAB must also submit an annual report providing information on system-wide health care costs, patient access to care, utilization, and quality of care that allows comparison by region, types of services, types of providers, and payers--both private insurers and Medicare. By January 1, 2015, and at least every other year thereafter, the IPAB will submit recommendations to slow the growth in national health care expenditures while preserving or enhancing quality of care. These

recommendations could be those that: (1) the Secretary of Health and Human Services (HHS) and other federal agencies could implement administratively; (2) may require federal legislation to be implemented; (3) may require state or local government legislation to be implemented; or (4) private entities can voluntarily implement.

Fast track legislative process

- By January 15 of each year, beginning in 2014, the IPAB must submit a proposal to Congress and the President for achieving Medicare savings targets in the following year.
- If the IPAB fails to submit a proposal to Congress and the President by January 15, the HHS Secretary must submit a proposal for meeting the savings targets to the President and the Medicare Payment Advisory Commission (MedPAC) by January 25 of that same year. The President must submit the Secretary's proposal to Congress within two days.
- The House and Senate Majority Leader or their designee must introduce the IPAB proposal the same day it is received (or on the first day the chamber is in session). If the proposal is not introduced within five days, any senator or representative can introduce it.
- The proposal must be referred to the Senate Finance Committee and the House Ways and Means and House Energy and Commerce Committees.
- By April 1, the Committees of jurisdiction are to complete their consideration of the proposal. Any committee that fails to meet that deadline will be discharged from further consideration.
- Congress cannot consider any bill or amendment that does not meet the IPAB targets or that would repeal or change the fast-track Congressional consideration process without a three-fifths vote (60) in the Senate. Non-germane amendments are not permitted.
- The HHS Secretary must implement the IPAB proposal on August 15 of the year in which the proposal is submitted. Recommendations regarding the physician fee schedule would take effect on January 1 the following year. If Congress does not pass the proposal before August 15, or if the President vetoes the proposal as passed by Congress, the original IPAB recommendations would take effect. (All policy changes affecting physicians that are not part of the physician fee schedule will be addressed in the regulatory process and take effect as soon as practicable.)

IPAB Board members

- The IPAB members are to include:
 1. 15 members appointed by the President, by and with the advice and consent of the Senate. In selecting individuals for nominations for appointments to the Board, the President shall consult with: (i) the majority leader of the Senate concerning the appointment of 3 members; (ii) the Speaker of the House of Representatives concerning the appointment of 3 members; (iii) the minority leader of the Senate concerning the appointment of 3 members; and (iv) the minority leader of the House of Representatives concerning the appointment of 3 members;
 2. The HHS Secretary, the Administrator of CMS, and the Administrator of the Health Resources and Services Administration (all of whom will serve ex officio as nonvoting members of the Board).

- Qualifications/Requirements for IPAB Members:
 1. Appointed members of the IPAB will include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, health facilities reimbursement, allopathic and osteopathic physicians, other providers of health services, and other related fields who provide a mix of professionals, broad geographic representation, and balance between urban and rural areas.
 2. IPAB members must include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and expertise in outcomes and effectiveness research and technology assessment. Members must also include individuals representing consumers and the elderly.
 3. Individuals who are directly involved in providing or managing the delivery of Medicare items and services may not constitute a majority of IPAB's membership.
 4. The President must establish a system for public disclosure by IPAB members of any financial and other potential conflicts of interest.
 5. No IPAB member may be engaged in any other business, vocation, or employment.